

Understanding and learning from organisational failure

K Walshe

Healthcare systems need better mechanisms for identifying, investigating, and learning from major organisational failures if they are to prevent such failures occurring in the future.

Every healthcare system has its disasters—high profile failures of care in which many patients are harmed, perhaps seriously, and lives are often lost. In the UK such tragic circumstances have come to light with alarming regularity in recent years,¹ and there has been a series of public inquiries into, for example, avoidable deaths in paediatric cardiac surgery in Bristol, negligent clinical practice in gynaecology in Kent, inappropriate post-mortem tissue removal and retention from children in Liverpool and, most recently and horrifically, the murder of over 200 patients in a period of 23 years by a general practitioner in Manchester.² The cumulative effect of this litany of misadventure is hard to judge, but it has certainly contributed to reducing the willingness of the public and the media to place their trust in clinical professionals and healthcare organisations, and has fuelled calls for more regulation and oversight of clinical practice and the performance of healthcare organisations.

Although the anatomy of these disasters is largely clinical—botched surgery, negligent diagnosis or treatment, errors in prescribing or administering drugs, clinical incompetence, and so on—subsequent inquiries and investigations suggest that their pathology is almost always organisational.³ These problems seem to happen in organisations with inadequate or weak leadership; organisational or geographical isolation and an inward looking closed culture; a lack of basic management systems and processes such as performance review and management; poor internal and external communication and a lack of openness or transparency; and disempowered groups of staff and patients who are unable to voice their concerns.⁴ Armed with this knowledge, one might expect that we could identify those organisations (or parts of them) which are prone to failure and prevent future failures from occurring. But the dismal repetitiveness with which such organisational failures happen suggests that this is far from straightforward. For example, in social care we have seen a succession of

inquiries into the deaths of children at the hands of their parents or carers over the last 30 years,⁵ culminating most recently in the case of Victoria Climbié discussed in the accompanying editorial by Marcovitch.⁶ After each inquiry, social workers, healthcare professionals, educators, the police, and other public services have been castigated for failing to spot the obvious signs that children were at risk and failing to act to protect them in time. In each case a picture has emerged of organisational failure—poor communication, inadequate systems for record keeping and case management, unrealistic workloads, weak or absent middle and senior management, and a lethargic culture of learned helplessness in which unacceptably poor standards of care become the norm. Each inquiry or investigation makes many recommendations but they are either not implemented or they do not work, for the tragedies keep happening.

There may be three reasons for this, related to (1) the way that instances of organisational failure are identified; (2) our approach to investigating and understanding their causes; and (3) the mechanisms for using that understanding to bring about changes which would make future recurrence less likely.⁷

Firstly, it is almost wholly a matter of chance whether an instance of organisational failure is brought to the surface and exposed, or lies concealed. Healthcare organisations and the healthcare professions have traditionally dealt with such problems informally and secretively,⁸ and it seems likely that there are many more instances of such disasters which never attract widespread public and media attention and are never subject to a formal inquiry or investigation. In some countries the process of medical negligence litigation reinforces this tendency to concealment through the use of non-disclosure agreements and out of court settlements, and market pressures among competing healthcare providers mean there are strong disincentives to honesty and openness. The responsibility for identifying major organisational failures and initiating an

investigation is often fragmented between professional regulators, healthcare providers, and government authorities. A better and clearer definition of the circumstances or instances which should trigger a formal investigation of organisational failure is needed, alongside more robust and coherent systems for initiating and managing such investigations or inquiries.

Secondly, the techniques used for understanding and learning from the causes of organisational decline and failure in healthcare organisations are rather limited. In the UK we rely too much on the reports of individual, ad hoc inquiries and investigations which are effectively single case studies of instances of organisational failure. These are often conducted by an inquiry panel led by a lawyer, which takes a quasi-judicial approach to finding out what happened and may be more effective at describing the events with forensic accuracy than at prescribing effective organisational changes which would prevent them happening again. The process of investigation is often slow and costly, but still lacks rigour and sophistication. Moreover, we have no mechanisms for accumulating investigatory expertise and building up a cumulative understanding of organisational failure across a series of such events.

Thirdly, there are few—if any—mechanisms for following up inquiries and investigations and ensuring that other healthcare organisations have learned from past mistakes and made changes which would make their recurrence less likely. Once an inquiry report has been published, public and media attention is short lived and the boring but crucial process of implementing its recommendations and making changes happen is often not followed through, or is left up to healthcare providers and professionals to do with little support or oversight. Unsurprisingly, some are better than others at this, and it seems reasonable to hypothesise that those organisations which are least effective at making such changes happen may also display more of the common characteristics or determinants of organisational failure which were outlined earlier.

If healthcare systems had better mechanisms for identifying, investigating, and learning from major organisational failures, they would almost certainly be better at preventing such failures in the future, and so would avoid the considerable harm that often results for patients, clinical professionals, and healthcare organisations. At the same time, more research is needed to develop a better, theoretically informed, and empirically grounded understanding of the causes and determinants of organisational failure and how they can be prevented.

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Climbié report

Learning from tragedies: clinical lessons from the Climbié report

H Marcovitch

Improvements in communications between healthcare workers and changes in consultant work plans are needed if we are to avoid another tragedy like that of Victoria Climbié.

In January 2001 in London, 8 year old Victoria Climbié's great-aunt and her partner were convicted of her murder. During the last few months of her life she had come to the attention of doctors in two hospitals and social workers in two local authorities, but she remained unprotected. In consequence, the Secretary of State for Health set up an independent inquiry under a senior judge, Lord Laming. It reported in January 2003.¹

Unusually, given the history of enquiries into similar cases in the UK, the prime criticism was directed not to those Lord Laming referred to as "... the handful of hapless, if sometimes inexperienced, front line staff", but to "... the managers and senior members of the authorities whose task it was to ensure ... services for children like Victoria ...".

The report calls for major national organisational changes: the Government has promised to respond this spring. It seeks further training for paediatricians and general practitioners which will be delegated to their Royal Colleges. Social service departments are given a list of tasks, as are National Health Service trusts. I shall deal only with the last of these.

NHS chief executives will have to complete an audit by the end of April on how they protect children. In May the Secretary of State will have the results, collated by the Commission for Health Improvement, on his desk.

In keeping with the thrust of Laming's critique, it will be "managers and senior members" rather than clinicians who will be responsible for undertaking this task. Nonetheless, there is a paradox as 10 of the 16 priority recommendations directed at healthcare workers direct doctors how they should behave when dealing with individual patients. Of the other six, one involves provision of interpreters where needed, one the correct completion of the identification sheet for every new patient contact, and just four require chief executives to carry out a governance role in monitoring the compliance of clinicians with certain aspects of their work with abused children. The moral and ethical responsibility will stay where it should be—with clinicians who owe children a duty of care. The onus therefore remains on front line staff, even though Laming appears to suggest otherwise.

The report's findings with regard to the hospital departments which dealt with Victoria make clear why this should be. Ten doctors in two paediatric units dealt with Victoria during her admissions of just over 24 hours and 14 days, respectively. Only one is accused by Laming of failing to diagnose physical abuse. Issues raised included:

- A nursing care plan did not refer to abuse even though it had been diagnosed by the admitting doctor.
- Doctors should interview such children alone (or with an interpreter)

without fear of compromising social service investigations.

- If a registrar and consultant disagree on diagnosis, their discussion should be noted.
- Delegated note keeping should be checked and agreed.
- Telephone or face-to-face discussions about a child must be recorded.
- Senior house officers (SHOs, junior residents) or nurses may not discharge such children from hospital and there must be a documented follow up plan.
- A full physical examination must be performed and documented within 24 hours of admission.
- Difficult conversations with possible abusers should not be left to SHOs.
- Doctors must provide full reports to social services departments and correct misunderstandings in writing.

Paediatricians reading this list may be forgiven for assuming they represent a summary of normal practice and asking themselves why it did not happen in this case. Few of the reasons have to do with inadequate medical knowledge. Most have to do with poor note keeping skills or chaotic working patterns.

At one point a specialist registrar who made a correct and prompt diagnosis had gone off duty by the time the consultant arrived because the latter was conducting a community clinic. They never conferred.

A registrar wrote a note of a consultant's ward round. The two doctors subsequently disputed the accuracy of the note. One question was whether "no physical abuse issues" would have been preferable to "no child protection concerns".

A locum SHO wrote a referral slip to the duty social worker. She believed it would provoke a visit. Laming pointed out the letter did not ask for a visit. It began: "Thank you for dealing with the social issues [of this child]".

Three separate messages were sent to a social worker but none referred unequivocally to non-accidental injury. The